77

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The ~~correct age~~ is especially important. Physicians: please write the causes of death clearly and legibly.

(M)

(1)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Dr. Ditto 8319

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Mos.

Hospital, institution, or street address where death occurred: Maryland Hotel

How long in hospital or institution? 7 Mos

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No.: Maryland Hotel (If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Daniel Cunningham Alter

3.(b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widower

6.(b) Name of husband or wife: Carrie

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): January 5 1871

8. AGE:	Years	Months	Days	If less than one day
	74	7	15	hrs. min.

9. Birthplace: Cearfoss Wash. Co. Md. (Town, county, and state)

10. Usual occupation: Transfer Operator

11. Industry or business: Retired

FATHER

12. Name: Frank Alter

13. Birthplace: Cearfoss Md.

MOTHER

14. Maiden name: Annie Cunningham

15. Birthplace: Cearfoss Md.

16. Informant: Mrs. Georgia Rohrer

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/24/45 (month) (day) (year)

Cemetery or crematory: Salem Reformed Cemetery

Location: near Cearfoss Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19 Aug 24 1945 (Date rec'd by registrar) Chas H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20 1945, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20-45 to Aug 20 1945

and that I last saw h— alive on Aug 20-45

Immediate cause of death: Died 8/20/45 11 P.M. Not seen

Due to: Body found 8/24/45 - 4 P.M.

Due to: Chr. Myocarditis

Other conditions: Arteriosclerosis

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E W Ditto Asst. Coroner M. D. or other

Address: Hagerstown Md. Date signed: 8/24/45

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AUG 27 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08320

Reg. Diat. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 days.

Hospital, institution, or street address where death occurred:

Wash. Co. Hospital

How long in hospital or institution? 19 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Kedysville Md R. 1

(If outside city or town limits, write RURAL and give nearest town)

Street No. Kedysville Md.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME Georgette Athey

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George E. Athey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August. 14. - 1866

8. AGE: Years	Months	Days	If less than one day
79	0	2	..... hrs. ..... min.

9. Birthplace: Near Winchester Virginia (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Own Home

FATHER 12. Name: George W. Rowland

13. Birthplace: Virginia

MOTHER 14. Maiden name: Susan McCarrol

15. Birthplace: Virginia

16. Informant: Mrs. J. W. Fleming

Address: Kedysville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 19 1945 (month) (day) (year)

Cemetery or crematory: Fairview Cemetary

Location: Kedysville Md.

18. Funeral director: Wm. J. Bast & Sons

Address: Boonsboro Md.

19. Aug. 17. 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/16 19 45, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/28 19 45, to 8/16 19 45

and that I last saw h.. alive on 8/16 19 45

Immediate cause of death	DURATION
Uremia	10 days
Due to: Arteriosclerotic cardiovascular disease	Unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M. D.

M. D. or other

Address: 154 W. Wash. St. Hagerstown Md. Date signed 8/17/45

RECEIVED
AUG 20 1945
BUREAU V.S.

Evidence for addition of sex & color is shown on MCM No. G 98 SEP 21 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08321

Reg. Diat. No. 306

1. PLACE OF DEATH

County Frederick

City or town Smithsburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Frederick

City or town Smithsburg Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. - -

(If rural, give LOCATION)

2.(a) If veteran, name war none

3. (a) FULL NAME Clarence Richardson Bachtell

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife Emma L. Bachtell

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 10-27-1871

8. AGE: Years 73 | Months 9 | Days 15 | If less than one day - hrs. - min.

9. Birthplace Oil City, Pa. (Town, county, and state)

10. Usual occupation Retired Rail Road Conductor

11. Industry or business

FATHER 12. Name Daniel Steward Bachtell

13. Birthplace Leitersburg Md

MOTHER 14. Maiden name Sallie Richardson

15. Birthplace Oil City Pa

16. Informant Mrs Anna Finkbeiner

Address Smithsburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 18 1945 (month) (day) (year)

Cemetery or ~~cemetery~~ Leitersburg

Location Leitersburg Md

18. Funeral director Geo. B. Hoover

Address Smithsburg Md

19. Aug 20th 1945 (Date rec'd by registrar) Geo. M. Ferguson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1945, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15, 1945, to Aug 9, 1945 and that I last saw him alive on Aug 9, 1945

Immediate cause of death	DURATION
Adeno carcinoma, mediastinal	
Due to	
Due to	
Other conditions Myocardial degeneration	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter L. Wolfinger M.D. M. D. or other

Address Waynesboro, Pa Date signed 9 Aug 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 13 1945
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (463)

CERTIFICATE OF DEATH

Reg. Diat. No. C8323 301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington County
City or town: Downsville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred:
Downsville Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Downsville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Downsville Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lloyd Kieffer Baker

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Jennie Smith Baker
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Aug. 12 1875

8. AGE: Years	Months	Days	If less than one day
70		5	hrs. min.

9. Birthplace: Frederick County Maryland
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Carpenter (built houses)

FATHER
12. Name: John Baker
13. Birthplace: Frederick County Md.

MOTHER
14. Maiden name: Mary Elizabeth Poffenbarger
15. Birthplace: Frederick County Md.

16. Informant: Jennie Smith Baker (wife)
Address: Downsville Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 19 1945 (month) (day) (year)
Cemetery or crematory: Manor Cemetery
Location: Near Tilghmanton Md.

18. Funeral director: Edith V Leaf
Address: #7 Church St. Williamsport, Md.

19. 8/19 19 45 (Date rec'd by registrar) Mrs Edna McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/17/45 19 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/7/45 19 to 8/17/45 19 and that I last saw him alive on 8/17/45 19

Immediate cause of death	DURATION
Carcinoma Pancreas	6 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Ralph L. Grimes M. D. or other
Address: Williamsport, Md. Date signed: 8/17/45

RECEIVED
AUG 21 1945
BUREAU V.S.

63

MARYLAND STATE DEPARTMENT OF HEALTH

Dr. Kneisley

2411 N. Charles St., Baltimore (13)

C8323

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown R # 4

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Years

Hospital, institution, or street address where death occurred:

Paramount

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown R # 4

(If outside city or town limits, write RURAL and give nearest town)

Street No. Paramount

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME ~~Rush Granville~~ Barrick, Rush Granville

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife --

6.(c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) January 10 1875

8. AGE: Years	Months	Days	If less than one day
70	6	29	..... hrs. ..... min.

9. Birthplace Sabillasville Fred. Co. Md. (Town, county, and state)

10. Usual occupation U.S.Patent Office

11. Industry or business Clerk

FATHER 12. Name Dr. Samuel Barrick

FATHER 13. Birthplace Sabillasville Md.

MOTHER 14. Maiden name Susan Harbaugh

MOTHER 15. Birthplace Sabillasville Md.

18. Informant Mrs. Howard Harbaugh

Address Hagerstown R # 4 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/13/45 (month) (day) (year)

Cemetery or crematory ~~Rose Hill~~ Greenwood Cemetery

Location Altoona Pa.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Aug 11. 1945 (Date rec'd by registrar) Elsie H Bowers Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH August 9 1945 19..... at 11.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 8, 1945 19..... to August 9 19 45

and that I last saw him alive on August 8, 1945 19.....

Immediate cause of death	DURATION
Coronary occlusion	30 min.
Due to Chronic myocarditis with congestive failure	Indef.
Due to	
Other conditions Chronic nephritis	Indef.

Previously attended by Dr. E. W. Ditto, Jr. Hagerstown, Md.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. B. Kneisley M. D.

Address 148 W. Washington St. Date signed 8/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

REC[illegible]
AUG 14 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

08324

Reg. Dist. No. 306

1. PLACE OF DEATH:

County: Washington

City or town: Leitersburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Washington

City or town: Leitersburg (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles Calvin Beard

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb 11 1867

8. AGE: Years	Months	Days	If less than one day
78	6	16	hrs. min.

9. Birthplace: Smithsburg District Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: John Beard

13. Birthplace: Md

MOTHER — 14. Maiden name: Catherine Shank

15. Birthplace: Md

16. Informant: G. R. Zeiser

Address: Hagerstown md #5

17. (Burial, cremation, or removal. Which?) Date thereof 8 29 1945 (month) (day) (year)

Cemetery or crematory: Smithsburg Cemetery

Location: Smithsburg Md

18. Funeral director: Walter G Grove

Address: Waynesboro Penna

19. Aug 29 1945 (Date rec'd by registrar) Geo. W. Torgerson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug - 27 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug - 25 1945, to Aug - 27 1945 and that I last saw h. alive on Aug - 26 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to: Generalized arteriosclerosis	? yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Walter H Weiland M.D. (M.D. or other)

Address: 12 W Main St. Waynesboro Pa. Date signed 8/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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SEP 1 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87-C)

08439

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Wash.

City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:
Washington Co. Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Penna. County Franklin

City or town Greencastle (If outside city or town limits, write RURAL and give nearest town)

Street No. N. Carlisle (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
Charles Franklin Beckner

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Bertha Gordon

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 20, 1880

8. AGE: Years	Months	Days	If less than one day
65	1	21	..... hrs. ..... min.

9. Birthplace Franklin Co., Pa. (Town, county, and state)

10. Usual occupation Retired Mechanic

11. Industry or business

FATHER
12. Name James Beckner
13. Birthplace Penna.

MOTHER
14. Maiden name Mary Pryor
15. Birthplace Penna.

16. Informant Gordon Beckner
Address Greencastle, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/14/45 (month) (day) (year)

Cemetery or crematory Green Hill

Location Waynesboro, Pa.

18. Funeral director Carol A. Deiter.

Address Greencastle, Pa.

19. Aug 11 1945 (Date rec'd by registrar) E. Kurtz Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1945 at 12:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 6 1945 to Aug 11 1945 and that I last saw h... alive on Aug 10 1945

Immediate cause of death	DURATION
Paralysis Agitans	5 yrs
Due to	
Due to	
Other conditions Acute urinary Retention (Include pregnancy within 3 months of death)	7 days

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE O. H. Binkley M.D. M. D. or other

Address Hagerstown Md Date signed 8/11/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 14 1945
BUREAU U. S.

88

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

CERTIFICATE OF DEATH

Reg. Dist. No. 08325 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 years
Hospital, institution, or street address where death occurred: Fountain Head Golf Course
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1200 Oak Hill Avenue
(If rural, give LOCATION)
2.(a) Ll veteran, name war

3.(a) FULL NAME: Norman J. Bentz

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Kathryn Bentz
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): September 17, 1891

8. AGE: Years	Months	Days	If less than one day
53	11	12	hrs. min.

9. Birthplace: Waynesboro, Pa. (Town, county, and state)
10. Usual occupation: Jeweler
11. Industry or business: Bentz & Mundey

FATHER
12. Name: Willaim M. Bentz
13. Birthplace: Mt. Holly, Pa.

MOTHER
14. Maiden name: Nancy H. Culp
15. Birthplace: Gettysburg, Pa.

16. Informant: Mrs. Norman J. Bentz
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-31-45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Maryland

19. Aug 31 1945 (Date rec'd by registrar) Grace H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 29 1945, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 29 1945 to Aug 29 1945
and that I last saw h[illegible] alive on Aug 29 1945 19

Immediate cause of death	DURATION
Coronary Disease	1 hour
Due to	
Due to Shock upon arrival	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: L. W. Sutz M. D. coroner
Address: Hagerstown Md Date signed: 8-31-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 4 1945
BUREAU V.S.

aug 7-no1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

08326

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:
County Washington
City or town Rm. Mar
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Summer Resident
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Pa. County Franklin
City or town Waynesboro
(If ontside city or town limits, write RURAL and give nearest town)
Street No. 18 N. North St
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Blaine Bishop, D.DS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 2, 1898

8. AGE:

Years	Months	Days	If less than one day
47	7	3	hrs. min.

9. Birthplace Carlisle Pa. (Town, county, and state)
10. Usual occupation Dentist
11. Industry or business

FATHER
12. Name U.S. Grant Bishop
13. Birthplace Newville, Pa.

MOTHER
14. Maiden name Lulu Zullinger
15. Birthplace Hope Shawsberg Pa.

16. Informant Mrs. U.S. Grant Bishop
Address Waynesboro, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/8/45 (month) (day) (year)
Cemetery or crematory Green Hill Cemetery
Location Waynesboro, Pa.

18. Funeral director Walter Y. Stone
Address 27½ Church St. Waynesboro, Pa.

19. Aug 7 1945 Geo. W. Ferguson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5 45 10:50P
19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 , to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
acute coronary occlusion	
Due to	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations no
Date of op.
Autopsy results no
PHYSICIAN: Please underline the canse to which death shonld he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE S. Robert Wells M. D. or other.
DEPUTY MEDICAL EXAM WASH. CO., MD.
Address Hagerstown, Md. Date signed Aug/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 13 1945
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 187

CERTIFICATE OF DEATH

C8327

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? 6 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 312 North Mulberry St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Thomas A. Bowers

3.(b) Social Security Number: 705 / 10 / 5956

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ella E. Bowers

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Oct 1, 1898.

8. AGE: Years	Months	Days	If less than one day
46	10	20	____ hrs. ____ min.

9. Birthplace: Cherry Run, W Va.
(Town, county, and state)

10. Usual occupation: Section Foreman

11. Industry or business: Wm Rail Road

FATHER
12. Name: Henry Bowers
13. Birthplace: Maryland

MOTHER
14. Maiden name: Alice Albricht.
15. Birthplace: West Virginia.

16. Informant: Mrs Ella Bowers
Address: Hagerstown, 312 N Mulberry

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 24, 1945. (month) (day) (year)

Cemetery or crematory: Staters Chapel

Location: Cherry Run W.Va.

18. Funeral director: Fred W. Kraiss.

Address: Hagerstown, Md.

19. Aug 24 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

3-20

20. DATE OF DEATH: August 21 1945, at P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-21-45 19__ to 8-21-45 19__ and that I last saw h__ alive on 8-21-45 19__

Immediate cause of death	DURATION
Shock	
Due to Falling accident 8/21/45	
Due to Multiple fracture of pelvis	
Due to Rupture of bladder	
Other conditions Internal Hemorrhage	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide or homicide: W M N P Date of 8/21/45 P.M.

Where did injury occur? yard (City or town) Hagerstown (County) Md. (State)

Injured at home, farm, industry, public place (where?) Work Yard

Means of injury struck by T.V. engine Injured at work? yes

23. SIGNATURE: [illegible] M. D. or other

Address: Hagerstown Md Date signed 8-24-45

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AUG 27 1945
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

08328

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs.
Hospital, Institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wash.
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 131 W. Bethel st
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Melvin Ross Burnett

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	—

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 30, 1940

8. AGE: Years: 5 | Months: 1 | Days: 12 | If less than one day: hrs. min.

9. Birthplace: Hagerstown, Wash. Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: William A. Burnett
13. Birthplace: Hagerstown, Md.

MOTHER
14. Maiden name: Elizabeth M. Lewis
15. Birthplace: Front Royal, Va.

16. Informant: Mrs. Elizabeth Burnett
Address: 131 W. Bethel Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/15/45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetary
Location: Hagerstown, Md

18. Funeral director: Wm. H. Downs
Address: 291 Frederick st Hagerstown

19. Aug. 15 1945 (Date rec'd by registrar) Chas H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 12 1945 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 3, 1945 to Aug. 12 1945 and that I last saw him alive on Aug. 11-45 19

Immediate cause of death: Tetanus — DURATION: 9 days
Due to: Convulsions
Due to: Lacerated Ft.
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: H. Campbell M. D. or other
Address: Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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AUG 17 1945
BUREAU V.S.

83

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Prather

CERTIFICATE OF DEATH

18329

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? I Week
Hospital, institution, or street address where death occurred:
Washington Co. Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown R.F.D #2
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Antietam Heights
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs Mary Dickson Byer

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Ernest
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Nov. 6 I879

8. AGE: Years	Months	Days	If less than one day
65 65	9	2I	...hrs. ...min.

9. Birthplace: Chambersburg Franklin CO Pa.
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business: Ow n Home

FATHER
12. Name: Rev William Dickson
13. Birthplace: NewvillePa

MOTHER
14. Maiden name: Mary Kuhn
15. Birthplace: Newville Pa.

16. Informant: Cpl. Dorothy J Henry
Address: Hagerstown. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/29/45 (month) (day) (year)
Cemetery or crematory: Cedar GroveCemetery
Location: Chambersburg Pa.

18. Funeral director: Andrew K Coffman
Address: Hagerstown Md.

19. Aug. 27 1945 (Date rec'd by registrar) Elwood E. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 27 1945 at 2.30 P.M. A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 16 1945 to Aug 27 1945 and that I last saw h... alive on Aug 27 1945

Immediate cause of death	DURATION
Terminal Broncho Pneumonia	48 hrs
Due to: Chronic Myocarditis Hy pertension	10 yrs
Due to: Anaemia (Aplastic)	2 mo
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

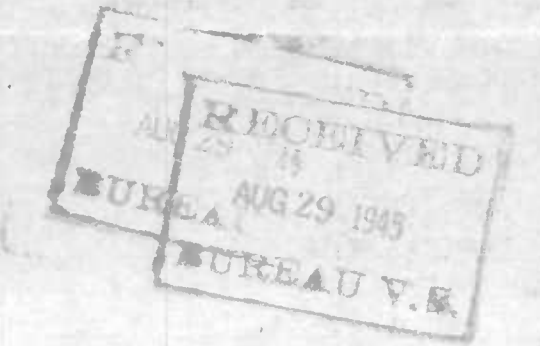
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: B Prather M. D.
Address: Hagerstown, Md. Date signed: 8/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15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AUG 29 1945
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (149)

CERTIFICATE OF DEATH

8330 #4

Reg. Dist. No. 301

1. PLACE OF DEATH:
County: Washington County
City or town: Williamsport, Md. RFD # 2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yrs.
Hospital, institution, or street address where death occurred:
Williamsport, Md. RFD # 2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Williamsport, Md. RFD 2
(If outside city or town limits, write RURAL and give nearest town)
Street No. Williamsport, Md RFD #
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American War

3.(a) FULL NAME
Robert B Byers

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margret G. Byers
60 yrs 6.(c) If alive, give age 60 yrs years

7. Birth date of deceased (mo., day, yr.): Nov. 20 1873

8. AGE: Years	Months	Days	If less than one day
71	8	27	...hrs. ...min.

9. Birthplace: Mercersburg Pa. (Town, county, and state)
10. Usual occupation: Blacksmith at Tannery
11. Industry or business: worked last 16 yrs ago
FATHER 12. Name: Edward Sharer Byers
13. Birthplace: Mercersburg Pa.
MOTHER 14. Maiden name: Ellen Sharar
15. Birthplace: Mercersburg Pa.
16. Informant: Margret G. Byers
Address: Williamsport, Md. RFD #
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 20 1945 (month) (day) (year)
Cemetery or crematory: Riverview Cemetery
Location: Williamsport, Md.
18. Funeral director: Edith V Leaf
Address: #7 Church St. Williamsport, Md.
19. Aug. 20 1945 (Date rec'd by registrar) Mrs. E. Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 16 1945 at 10:30 A.M. Private
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 16 1945, to Aug. 16 1945
and that I last saw h...alive on Not at all 19...
Immediate cause of death: Accidental Struck by a R.Road Locomotive - While trespassing on W.M.R.R. tracks
Due to: Fracture of Skull
Fracture of Right Lower Leg
Due to: Shock -
Dead upon Examiners arrival.
Other conditions

DURATION: Sudden Death

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...
Autopsy results: None -
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury Injured at work?

Substitute Coroner
23. SIGNATURE: Felix Duillon M. D. or other
Address... Date signed 8/17 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 21 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08331

Reg. Diat. No. 306

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Hard Smithsburg
City or town Hagerstown md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Hard
City or town Smithsburg md
(If outside city or town limits, write RURAL and give nearest town)
Street No. none
(If rural, give LOCATION)
2.(a) If veteran, name war none

3. (a) FULL NAME Mrs. Nettie Salome Charles

3. (b) Social Security Number none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife —

B.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 6, 1879

8. AGE: Years	Months	Days	If less than one day
66	4	7	— hrs. — min.

9. Birthplace near Smithsburg md (Town, county, and state)

10. Usual occupation Housekeeping

11. Industry or business —

FATHER
12. Name Geo. Carr.
13. Birthplace Ohio.

MOTHER
14. Maiden name Georgie Lyday
15. Birthplace Ohio.

16. Informant Jarvis A. Charles.
Address Smithsburg md

17. Burial (Burial, cremation, or removal? Which?) Date thereof 8-16-1943 (month) (day) (year)
Cemetery or crem. Smithsburg md
Location Smithsburg md

18. Funeral director Geo. B. Koons
Address Smithsburg md

19. Aug 15 1943 (Date rec'd by registrar) Geo. W. Ferguson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 13 1943 at 3 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 9 1943 to Aug 13 1943
and that I last saw h alive on Aug 13 1943

Immediate cause of death	DURATION
Chronic Myocarditis	
Myocardial insufficiency	6 days
Due to Hypertension	
Due to chronic Nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE B. [illegible] Gaither M. D. or Coroner
Address Hagerstown Md Date signed Aug. 14, 43

RECEIVED
AUG 25 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08332

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:
County: Washington
City or town: Smithsburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Years
Hospital, institution, or street address where death occurred:
Maple Ave
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Smithsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. Maple Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Maggie Hartle Clopper

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband: Charles
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): October 14 1876

8. AGE: Years	Months	Days	If less than one day
68	9	24	..... hrs. ..... min.

9. Birthplace: Beaver Creek Wash. Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: George S. Hartle
13. Birthplace: Beaver Creek Md.

MOTHER
14. Maiden name: Mary E. Gantz
15. Birthplace: Beaver Creek Md.

16. Informant: Mr. Charles Clopper
Address: Smithsburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/10/45 (month) (day) (year)
Cemetery or crematory: Rest Haven Cemetery
Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. Aug 9th 1945 (Date rec'd by registrar) Geo. W. Fogmon Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8 1945, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 8, 1945, to Aug 8 1945 and that I last saw h[illegible] alive on Aug 8 1945

Immediate cause of death	DURATION
Myocarditis, chronic	
Due to	
Due to	
Other conditions: Acute urticaria, Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Walter L Wolfinger M. D. or other
Address: Waynesboro Pa Date signed: Aug 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 13 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08333

Reg. Dist. No. 300

1. PLACE OF DEATH:

County: Washington

City or town: Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: William Oliver Cox

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Daisy Wyand

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 27, 1871

8. AGE: Years	Months	Days	If less than one day
73	8	27	..... hrs. ..... min.

9. Birthplace: Sharpsburg, - Wash. - Maryland
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER
12. Name: William I. Cox
13. Birthplace: Sharpsburg, Md.

MOTHER
14. Maiden name: Ann Otto
15. Birthplace: Sharpsburg, Md.

16. Informant: Mrs. Clifton Smith

Address: Sharpsburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 26, 1945 (month) (day) (year)

Cemetery or crematory: Mt. View

Location: Sharpsburg, Md

18. Funeral director: R. I. Earnshaw

Address: Keedysville, Md.

19. 9/28-45 (Date rec'd by registrar) E. C. Boyer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 23 19 45 at 9:50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 1945 to Aug. 23 1945 and that I last saw h[illegible] alive on Aug. 23 1945 19.....

Immediate cause of death	DURATION
(a) Thrombo-phlebitis of the left Sub-Clavian Vein.	5 Months.
Due to (b) Chronic Myocardial with great Cardiac Hypertrophy	?
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Walter H. Sheads M. D.
M. D. or other

Address: Sharpsburg, Md. Date signed 8/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1945
BUREAU V.S.

54

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

08334

CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington County
City or town: Hagerstown Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Williamsport RFD #1 (If outside city or town limits, write RURAL and give nearest town)
Williamsport Md. RFD #1
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John James Crilly

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	divorced

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May (Unknown) 1883

8. AGE: Years	Months	Days	If less than one day
62			..... hrs. ..... min.

9. Birthplace: Clearspring Md (Town, county, and state)
10. Usual occupation: Labor
11. Industry or business: General Labor

FATHER
12. Name: William Quilley
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elizabeth Miller
15. Birthplace: Clearspring Md.

16. Informant: Mrs. Martha Leggett
Address: Boonsboro Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 9 1945 (month) (day) (year)
Cemetery or crematory: Riverview Cemetery
Location: Williamsport, Md.

18. Funeral director: Edith V Leaf
Address: #7 Church St. Williamsport, Md.

19. Aug 7 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 6 1945, at 11:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 5 1945, to Aug 6 1945
and that I last saw him alive on Aug 6 1945

Immediate cause of death	DURATION
cerebral apoplexy	1 day
Due to: hypertension	1 year
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: Ralph F. Young M. D. or other
Address: Williamsport Md. Date signed: Aug 7 1945

AUG 9 1945
BUREAU V.S.

71

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

CERTIFICATE OF DEATH

08335

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 68 years
Hospital, Institution, or street address where death occurred:
139 N. Cannon Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wash.
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 139 N. Cannon Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Harry Edward Doarnberger

3.(b) Social Security Number: 214-09-6332

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Nannie Doarnberger
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): January 29, 1877

8. AGE: Years	Months	Days	If less than one day
68	6	16	...hrs. ...min.

9. Birthplace: Hagerstown, Wash., Md. (Town, county, and state)
10. Usual occupation: Watchman
11. Industry or business: Shoe Industry
FATHER 12. Name: Adam Doarnberger
13. Birthplace: Germany
MOTHER 14. Maiden name: Rose Fridinger
15. Birthplace: Hagerstown, Md.
16. Informant: Mrs. Nannie Doarnberger
Address: Hagerstown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 18, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Md.
18. Funeral director: Scott F. Minnich & Son
Address: Hagerstown, Md.
19. Aug. 17. 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15, 1945, at 8:55a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 1 1945, to August 15 1945 and that I last saw him alive on August 15 1945

Immediate cause of death	DURATION
Carcinoma of Urinary Bladder, with	10 mo
Due to Generalized metastasis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: O H Binkley M.D.
M. D. or other
Address: Hagerstown, md Date signed: 8/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 20 1945
BUREAU V.S.

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

Dr. Wells 08336

50

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Hours

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 3 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Wilsons

(If outside city or town limits, write RURAL and give nearest town)

Street No. State Road

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Nelson S. Draper

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Minnie

6.(c) If alive, give age: —

7. Birth date of deceased (mo., day, yr.): March 3 1877

8. AGE: Years	Months	Days	If less than one day
68	5	0	...hrs. ...min.

9. Birthplace: Clearspring Wash. Co. Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farm

FATHER

12. Name: John Z. Draper

13. Birthplace: Clearspring Md.

MOTHER

14. Maiden name: Mary Ensminger

15. Birthplace: Clearspring Md.

16. Informant: John A. ?Witmer

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/6/45 (month) (day) (year)

Cemetery or crematory: St. pauls cemetery

Location: near Clearspring Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Aug. 4 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH: August 3 1945 19... at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Vascular hypertension	4 yrs
Due to: cerebral hemorrhage	36hrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no

Date of op.:

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. Ruhrs Wells DEPUTY MEDICAL EXAM. WASH. CO., MD.

M. D.

Address: Hagerstown, Md. Date signed: Aug 4/45

RE
AUG 7 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-D

08337

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 years
Hospital, institution, or street address where death occurred:
117 Westside Ave.,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 117 Westside Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Jesse Dusing

3. (b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Caroline
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 27 1855.

8. AGE: Years	Months	Days	If less than one day
89	11	1	..... hrs. ..... min.

9. Birthplace: Frederick County (Town, county, and state)
10. Usual occupation: Retired farmer
11. Industry or business

FATHER
12. Name: Jacob Dusing
13. Birthplace: Frederick County

MOTHER
14. Maiden name: Not Known
15. Birthplace: Not Known

16. Informant: Jacob Dusing
Address: Hagerstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 30 1945 (month) (day) (year)
Cemetery or ~~crematory~~: United Brethern
Location: Frederick County

18. Funeral director: Fred W. Kraiss
Address: Hagerstown

19. Aug 29 19 45 Chas H. Bowers, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION 10"30

20. DATE OF DEATH: August 28 19 45, at A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 28-45 19 Aug 28-45 19
and that I last saw h.: alive on Aug 28-45 19

Immediate cause of death	DURATION
Senility	
Due to: C	4 yrs
Due to: Ch. Myocarditis	
Other conditions: Dec'd was cremated	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: H. W. Dotts M. D. or other
Address: Hagerstown Date signed: 8-29-45

M

1

1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 31 1945
BUREAU V S

Dr Kohler

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74a

CERTIFICATE OF DEATH

08338

Reg. Dist. No. 366

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Greensburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Entire life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Washington
City or town: Greensburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. Smithsburg #1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Carrie Virginia Fishack

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Single

6.(b) Name of husband or wife: Ext
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct. 13 / 867

8. AGE: Years	Months	Days	If less than one day
77	9	20	hrs. min.

9. Birthplace: Greensburg Md (Town, county, and state)
10. Usual occupation: House Wark
11. Industry or business

FATHER
12. Name: George R Fishack
13. Birthplace: Washington Co Md

MOTHER
14. Maiden name: Sarah C Bachtell
15. Birthplace: Washington Co Md

16. Informant: Charles G Fishack
Address: Smithsburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 6 1945 (month) (day) (year)
Cemetery or crematory: Stouffers Mennonite Cemetery
Location: near Smithsburg Md.

18. Funeral director: Walter G Grove
Address: Waynesboro Pa

19. Aug 6 1945 (Date rec'd by registrar) Geo. W Ferguson Registrar Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 3 1945 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1945 to Aug 3 1945 and that I last saw h. alive on Aug 3 1945

Immediate cause of death: Cerebral Thrombosis — DURATION: 4 days
Due to: Infarct Cerebrum — 7 days
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: G. G K Kohler M. D. or other
Address: Smithsburg Md Date signed 8/4/45

RECEIVED
AUG 13 1945
BUREAU OF

Dr. Ditto 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 302 08339

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
310 Bryan Place
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 310 Bryan Place
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Ida Downin Freed

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): June 29 1861

8. AGE: Years	Months	Days	If less than one day
84	1	3	....hrs. ....min.

9. Birthplace: Hagerstown Wash. Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: Samuel Downin
13. Birthplace: Williamsport Md.
MOTHER 14. Maiden name: Elizabeth Miller
15. Birthplace: Williamsport Md.
16. Informant: Mrs. Florence Freed
Address: Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/5/45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.
18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19. Aug. 4 1945 (Date rec'd by registrar) Charles H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 2 1945 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1- 41 to Aug 2- 45 and that I last saw her alive on July 1- 45

Immediate cause of death	DURATION
Chr Myocarditis	6 yr
Due to: Senile arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H W Ditto M. D. or other
Address: Hagerstown Md. Date signed: 8/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 7 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

08340

Reg. Dist. No. 304

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Washington
City or town Hancock
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hancock
(If outside city or town limits, write RURAL and give nearest town)
Street No. Washington
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Cynthia Elizabeth (Householder) Fuss

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife John M Fuss
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 21, 1878

8. AGE: Years	Months	Days	If less than one day
67	3	17	— hrs. — min.

9. Birthplace Spohrs Crossroads, Morgan Co., W. Va.
(Town, county, and state)
10. Usual occupation —
11. Industry or business —
FATHER 12. Name Daniel T. Householder
13. Birthplace Spohrs Crossroads, W. Va.
MOTHER 14. Maiden name Frances Pentoney
15. Birthplace Spohrs Crossroads, W. Va.
16. Informant George E. Fuss
Address Hancock, Md.
17. Burial Date thereof Aug. 12, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Spohrs Crossroads Church Cemetery
Location Spohrs Crossroads, W. Va.
18. Funeral director Charles R. Bast
Address Hancock, Md.
19. Aug 9-11 1945 J. A. Keller
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1945 at 10 45 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 1945, to Aug 7 1945
and that I last saw her alive on Aug 7 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Chronic Myocard.	
Due to Diabetes	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE F. M. Kaffer M. D. or other
Address Hancock Md. Date signed 8/11/45

RECEIVED
AUG 16 1945
BUREAU

84

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

118341

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington County
City or town: Hagerstown Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Worked at Plant
Hospital, institution, or street address where death occurred:
#1 Gate Plant 2 Fairchilds
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: 112 Conococheague St.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Williamsport, Maryland
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Clarence Andrew Gaylor

3.(b) Social Security Number: 216-14-5834

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Rachell Harsh Gaylor
6.(c) If alive, give age: 55 yrs years

7. Birth date of deceased (mo., day, yr.): Jan. 17 1884

8. AGE: Years	Months	Days	If less than one day
61	7	2	..... hrs. ..... min.

9. Birthplace: Sharpsburg Pike Md.
(Town, county, and state)
10. Usual occupation: Guard
11. Industry or business: Fairchilds Plant Hagerstown

FATHER
12. Name: Andrew Gaylor
13. Birthplace: Maryland

MOTHER
14. Maiden name: Savannah (Unknown)
15. Birthplace: Maryland

16. Informant: Rachell Harsh Gaylor
Address: 112 Conococheague St. Williamsport

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 29 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Maryland

18. Funeral director: Edith V Leaf
Address: #7 Church St. Williamsport, Md.

19. Aug 28 1945 (Date rec'd by registrar) Edward H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26, 1945, at 5.50a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 26 1945, to August 26 1945
and that I last saw h.. alive on August 26 1945

Immediate cause of death	DURATION
Coronary occlusion	15 minutes
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R B Nowvert MD M. D. or other
Address: Hagerstown Md Date signed August 28 19 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 30 1945
BUREAU V

Dr. Victor Miller
08342 90

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-C)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Day
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Fiddlersburg Road
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: John M. Glassbrenner

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Mary
6.(c) If alive, give age: —
7. Birth date of deceased (mo., day, yr.): January 15 1880

8. AGE: Years	Months	Days	If less than one day
65	7	15	....hrs. ....min.

9. Birthplace: palmyra Lebanon Co Pa. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Farm

FATHER
12. Name: No Record
13. Birthplace: No Record

MOTHER
14. Maiden name: No Record
15. Birthplace: No Record

16. Informant: Horold Hoffman
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/3/45 (month) (day) (year)
Cemetery or crematory: Bellvieu Cemetery
Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. Sept 3 1945 (Date rec'd by registrar) Chas H. Bowers Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH: August 30 1945 at 8.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from aug 1 - 1945 to aug 30 1945 and that I last saw him alive on august 1 1945

Immediate cause of death	DURATION
Chronic Endo Carditis.	2
" Nephritis.	"
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury: .... Injured at work?

Victor D. Miller

23. SIGNATURE: .... M. D. or other
Address: .... Date signed 8/30-1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH INKING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 5 1945
BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08343 303

★ Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Wilson Dist
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Antietam, Route 2
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Antietam, Md, Route 2
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Charles William Hammond.

3.(b) Social Security Number: 212 / 14 / 7112

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 11, 1875.

8. AGE: Years	Months	Days	If less than one day
69	11	000	hrs. min.

9. Birthplace: Sharpsburg, Md (Town, county, and state)
10. Usual occupation: Laboror
11. Industry or business
FATHER 12. Name:
FATHER 13. Birthplace: Hardy Hammond
MOTHER 14. Maiden name: Washington County
MOTHER 15. Birthplace: Not known
16. Informant: Ruby Gordon
Address: Wilson Dist
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 13, 1945 (month) (day) (year)
Cemetery or crematory: Lutheran
Location: Sharpsburg, Md.
18. Funeral director: Russell Earnshaw
Address: Keedysville
19. Aug 11 1945 (Date rec'd by registrar) Henry M. Fribley Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/11/45 19 ..., at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-10-45 19 ... to 8/11/45 19 ...
and that I last saw h... alive on 8/10/45 19 ...

Immediate cause of death	DURATION
Congestive Heart Failure	6 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Hagerstown Md. Date signed 8/11/45

RECEIVED
SEP 26 1945
BUREAU V.E.

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

CERTIFICATE OF DEATH

Dr. Bell 68344

24

FILM No. G 97 AUG 31 1945

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 324 Vista St.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Marion Louise Hankins

3.(b) Social Security Number: 220-18-0528

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Shealds

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): January 1 1901

8. AGE: Years	Months	Days	If less than one day
44 47-	7	9	...hrs. ...min.

9. Birthplace: Waynesboro Franklin Co. Pa/ (Town, county, and state)

10. Usual occupation: Southern Ribbon Co.

11. Industry or business: Winder

FATHER

12. Name: William H. Andrews

13. Birthplace: Clearspring Md.

MOTHER

14. Maiden name: Eliza Brumbaugh

15. Birthplace: Waynesboro Pa/

16. Informant: Cpl. Shealds Hankins

Address: Camp Ritchie Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/12/45 (month) (day) (year)

Cemetery or crematory: Beautiful View Cemetery

Location: Middleburg Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Aug. 11, 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10 1945, 19..., at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24, 1945 to Aug. 10, 1945 and that I last saw her alive on August 10, 1945

Immediate cause of death	DURATION
Diabetes Mellitus	?
Due to	
Due to	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: No operations

Date of op.

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)...

Means of injury... Injured at work?

23. SIGNATURE: La Bell M. D. or other

Address: Hagerstown, Md Date signed: 8/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 14 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (39)

CERTIFICATE OF DEATH

8345

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington.

City or town: Hagerstown

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Washington Co. Hospital

Stay in hospital or inst. (yrs., or mos., or days): 5 hours

Stay in this community (yrs., or mos., or days): 5 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland (OUTSIDE CORPORATE LIMITS) County: Wash.

City or town: Hagerstown Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 816 Concord St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Richard Young Hovermale

3. (b) Social Security Number:

4. Sex	5. Color or race	5.(a) Single, married, widowed, or divorced
Male	White	Single

B (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): August 21, 1945

8. AGE: Years | Months | Days | If less than one day: 5 hrs. ____ min.

9. Birthplace: Hagerstown (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Victor Richard Hovermale

13. Birthplace: Hagerstown, Md.

MOTHER — 14. Maiden name: Vivian Doretta Young

15. Birthplace: Charlestown, W.Va.

16. Informant: Mrs. V. R. Hovermale

Address: 816 Concord St. Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-23-45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. (Date rec'd by registrar) Aug. 23 1945 Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 22 1945, at 12.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 21, 1945, to Aug. 22 1945, and that I last saw him alive on Aug. 21 1945.

Immediate cause of death	DURATION
Premature 6 months gestation.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

20 operations

20 autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: M. S. Cumberland, M. D. or other

Address: Hagerstown, Md. Date signed 8/22/45

RECEIVED
AUG 25 1945
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-a)

CERTIFICATE OF DEATH

08346

Reg. Dist. No. 200

1. PLACE OF DEATH:
County: Washington
City or town: Sharpsburg RFD Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 79 yrs
Hospital, institution, or street address where death occurred:
Sharpsburg Md. RFD
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Sharpsburg RFD
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Albert Jackson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Caroline Summers deceased
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 15 1866

8. AGE: Years	Months	Days	If less than one day
79	3	30	hrs. min.

9. Birthplace: Sharpsburg Md. (Town, county, and state)
10. Usual occupation: Farm Laborer
11. Industry or business: Farm

FATHER
12. Name: Ernie D. Jackson
13. Birthplace: Frostburg Va.

MOTHER
14. Maiden name: Jane Jackson
15. Birthplace: Unknown

16. Informant: Mrs. Gay Williams (daughter)
Address: 33 N. Johnthan St. Hagerstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 19 1945 (month) (day) (year)
Cemetery or crematory: Tolsen Church Cemetery
Location: Sharpsburg Maryland

18. Funeral director: Edith V Leaf
Address: #7 Church St. Williamsport, Md.

19. 8/17 1945 (Date rec'd by registrar) C. C. Rayne Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14 1945 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 1945 to Aug. 13 1945 and that I last saw him alive on Aug. 14 1945

Immediate cause of death	DURATION
Uremia	1 week.
Due to: Cardio-Vascular	2 yrs.
Due to: Renal Disease	5 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Walter H. Shealy M.D. M. D. or other
Address: Sharpsburg, Md. Date signed: 8/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
SEP 6 1945
BUREAU U.S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

8347 2

1. PLACE OF DEATH

County Washington Registration Dist. No. 307

Village or City Sandy Hook, Md. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 67 yrs. 1 mos. 13 ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Roy Edwin Johnson If U. S. Veteran, specify WAR

(a) Residence: No. Sandy Hook, Md. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie D. Johnson

6. DATE OF BIRTH (month, day, and year) July 2 1878

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	1	13	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Conductor

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. B.&O RR.Co.

10. Date deceased last worked at this occupation (month and year) 1940

11. Total time (years) spent in this occupation 20yrs

12. BIRTHPLACE (city or town) Sandy Hook (State or country) Maryland

FATHER

13. NAME Edwin Johnson

14. BIRTHPLACE (city or town) Sandy Hook, Md. (State or country)

MOTHER

15. MAIDEN NAME Harriet Mc,Abee

16. BIRTHPLACE (city or town) Sandy Hook, Md. (State or country)

17. INFORMANT Mrs Roy E. Johnson (Address) Knoxville, Md. R.R. # 1

18. BURIAL, CREMATION, OR REMOVAL (Burial) Place Brownsville, Md. Date Aug 18, 1945

19. UNDERTAKER J. L. Eachles. (Address) Bolivar, W.Va.

20. FILED Aug 18, 1945 Cornelius W. Castle Deputy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Aug (Month) 15 (Day), 1945 (Year)

22. I HEREBY CERTIFY That I attended deceased from Aug 12, 1945, to Aug 15, 1945

I last saw h.. alive on Aug 14, 1945; death is said to have occurred on the date stated above, at 11:15A.M

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	Year
Other Contributory Causes of Importance:	
Carcinoma of Prostate ?	

Name of operation Dete of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Menner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) M. D.

(Address)

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED
AUG 22 1945
BUREAU V.S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Evidence for change of age & date of birth of deceased is shown on

53

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N, Charles St., Baltimore (B-2)

CERTIFICATE OF DEATH

08348

Reg. Dist. No. 302

FILM No G 97 AUG 31 1945

1. PLACE OF DEATH: County Washington

City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 yrs

Hospital, Institution, or street address where death occurred: 50 W. North St.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No. 50 W. North St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Florence Wardy Jones

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Cal	Married

6.(b) Name of husband or wife Joseph Jones

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 28 1876 December 12, 1885

8. AGE: Years	Months	Days	If less than one day
68 55			hrs. min.

9. Birthplace Williamsport Md (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Robert Stevenson

13. Birthplace ?

MOTHER 14. Maiden name Florence Stevenson

15. Birthplace ?

16. Informant Miss Alice Jones

Address 50 W. North St

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 6 45 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md

18. Funeral director William H. Downey

Address 84 N Frederick St

19. Aug 6 1945 (Date rec'd by Registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/3 1945 at 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1945 to July 22 1945

and that I last saw her alive on July 22 1945

Immediate cause of death	DURATION
Chronic Endocarditis	15 y
" Nephritis.	
Due to ?	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Victor D. Miller M. D. or other

DR. VICTOR D. MILLER

Address 121 W. WASHINGTON, ST. Date signed 8/4 1945

HAGERSTOWN, MD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 8 1945
BUREAU V.S.

8349 80

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Washington Co. Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hancock
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mildred Schuster Jones

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Married

6.(b) Name of husband ~~or wife~~: Rev. H. Kearney Jones
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 23, 1906

8. AGE: Years	Months	Days	If less than one day
39	5	0	___ hrs. ___ min.

9. Birthplace: Towson, Hartford, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: Charles C. Schuster
13. Birthplace: Hartford Co., Md.

MOTHER
14. Maiden name: Emma E. Barrows
15. Birthplace: Baltimore, Md

16. Informant: Rev. H. Kearney Jones
Address: High St., Hancock, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 27, 1945 (month) (day) (year)
Cemetery ~~or crematory~~: Parkwood
Location: Baltimore Md.
18. Funeral director: Charles R. Bast
Address: Hancock, Md.
19. Aug 24 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 23, 1945, at 6 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 22 1945, to Aug 23, 1945
and that I last saw her alive on Aug 23, 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	4 days
Due to: Hypertensive cardio-vascular disease	6 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R. L. Stauffer, M. D.. M. D. or other
Address: Hagerstown, Md Date signed Aug 24, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 27 1945
BUREAU V.S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

3

(M)

83-a

08350

1. PLACE OF DEATH

County: Washington — Registration Dist. No. 307

Village or City: Sandy Hook — No. ___ St., ___ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 46 yrs. ___ mos. ___ ds. How long in U. S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

2. FULL NAME Blanche Eugene Keyser — If U. S. Veteran, specify WAR ___

(a) Residence: No. Sandy Hook, Md. St., ___ Ward. ___
(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: John R. Keyser

6. DATE OF BIRTH (month, day, and year): Oct 24 1873

7. AGE

Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
71	9	26	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: House Keeping

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Own Home

10. Date deceased last worked at this occupation (month and year): 1945

11. Total time (years) spent in this occupation: 46yrs

12. BIRTHPLACE (city or town) (State or country): Leesburg, Va.

FATHER

13. NAME: Addison C. Williams

14. BIRTHPLACE (city or town) (State or country): Not Known

MOTHER

15. MAIDEN NAME: Elizabeth R. Bursey

16. BIRTHPLACE (city or town) (State or country): Not Known

17. INFORMANT: Daniel W. Keyser
(Address): Knoxville, Md. R.R. # 1

18. BURIAL, CREMATION, OR REMOVAL: Burial
Place: Sandy Hook, Md. Date: Aug 23 1945

19. UNDERTAKER: J. H. Eackles,
(Address): Bolivar, W.Va.

20. FILED: Aug 21 1945 Cornelius W. Castle, Deputy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Aug 20 1945
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Aug 18 1945, to Aug 20 1945

I last saw h[er] alive on Aug 19 1945; death is said to have occurred on the date stated above, at 9:50 A.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows: — Date of onset

Cerebral Hemorrhage — 2 days

Other Contributory Causes of Importance:

Name of operation ___ Date of ___

What test confirmed diagnosis? ___ Was there an autopsy? ___

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ___ Date of injury ___, 19__

Where did injury occur? ___
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ___

Nature of injury ___

24. Was disease or injury in any way related to occupation of deceased? ___

If so, specify ___

(Signed) [illegible signature] M. D.

(Address) Brunswick, Md.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a **clerk**.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

08351

57

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 years
Hospital, Institution, or street address where death occurred: 56 E. Franklin St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 56 E. Franklin St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: Mary Louise Schwinger Koons

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife: Charles A. Koons
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 31, 1879

8. AGE: Years	Months	Days	If less than one day
65	11	6	hrs. min.

9. Birthplace: Hagerstown, Wash., Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: George H. Schwinger
13. Birthplace: Hagerstown, Md.

MOTHER
14. Maiden name: Sarah L. Stouffer
15. Birthplace: near Hagerstown, Md.

16. Informant: Harry C. Schwinger
Address: Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 10, 1945 (Month) (day) (year)
Cemetery or crematory: Green Hill Cemetery
Location: Waynesboro, Penna.

18. Funeral director: Scott F. Minnich & Son
Address: Hagerstown, Md.

19. Aug. 8, 1945 (Date rec'd by registrar) Ghast H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 7, 1945, at 2:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 7 1945 to August 7 1945 and that I last saw her alive on August 7 1945

Immediate cause of death	DURATION
Coronary occlusion	10 mins
Due to	
Due to	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R B Mowrer M.D. M. D. or other
Address: Hagerstown Md Date signed: 4/8/45

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3rd)

CERTIFICATE OF DEATH

Reg. Diat. No. 08352

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Washington

City or town Sandersville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Frederick

City or town Rural Frederick
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME John F. Elmer Mayne

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

B.(b) Name of husband or wife Ada Mayne B.(c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) March 16, 1862

8. AGE: Years	Months	Days	If less than one day
83	5	13	hrs. min.

9. Birthplace Middletown, Frederick Co. Md.
(Town, county, and state)

10. Usual occupation Retired Farmer.

11. Industry or business

FATHER 12. Name Lawson Mayne

13. Birthplace Middletown, Md.

MOTHER 14. Maiden name Martha Crome

15. Birthplace Middletown, Md.

16. Informant Howard Main

Address New Market, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-31-45 (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Middletown, Md.

18. Funeral director Gladhill's

Address Middletown, Md.

19. Aug 30 1945 (Date rec'd by registrar) Geo. W. Ferguson Registrar

MEDICAL CERTIFICATION 1945 P

20. DATE OF DEATH ~~Aug 29~~ Sept 28, 1945 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25 1945 to Aug 29 1945 and that I last saw h... alive on Aug 29 1945

Immediate cause of death	DURATION
Pulmonary Edema	12 hrs
Due to Myocarditis	15 yrs
Due to Arteriosclerosis	20 yrs
Other conditions Prostatic hypertrophy	6 yrs

(Include pregnancy within 3 months of death)

Major findings of operations, —

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. G. Kohler M. D. or other

Address Sandersville Date signed 8/30/45

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55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

08353

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred: 40 East Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 40 East Ave,

(If rural, give LOCATION)

2.(a) If veteran, name war: No.

3.(a) FULL NAME: Frank I. McCleary

3.(b) Social Security Number: 214 / 09 / 0421.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Christabell.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 14, 1889.

8. AGE: Years	Months	Days	If less than one day
56	1	22	hrs. min.

9. Birthplace: Greencastle, Pa. (Town, county, and state)

10. Usual occupation: ~~Greencastle~~

11. Industry or business: Barber

FATHER 12. Name: Frank McCleary

FATHER 13. Birthplace: Greencastle

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Franklin County

16. Informant: Mrs. Frank McCleary

Address: Hagerstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 7, 1945. (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Greencastle, Penna.

18. Funeral director: Fred W. Kraiss.

Address: Hagerstown, Md.

19. Aug 7 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

10-45

20. DATE OF DEATH: August 5 19 45, at A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9 19 45 to August 5 19 45

and that I last saw h[im] alive on August 5, 19 45

Immediate cause of death	DURATION
Cancer of Splenic flexure of colon	1 year
Due to	
Due to	
Other conditions (Intest peritoneum) Intestinal hemorrhage	2 hours

(Include pregnancy within 3 months of death)

Major findings of operations: 0

Date of op.

Autopsy results: 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: N Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R. B. Mowbray M.D.

Address: Hagerstown, Md. M. D. or other

Date signed 8/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08354 62

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Five Years
Hospital, Institution, or street address where death occurred:
650 Pennsylvania Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 650 Pennsylvania ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mrs Francis Mitchell

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed.

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
53			hrs. min.

9. Birthplace: Gastonia N.C. (Town, county, and state)
10. Usual occupation: General housework.
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Rev Walter Campher.
Address: 650 Pennsylvania ave.
17. Burial. Date thereof Aug 18. 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery.
Location: Hagerstown Md.
18. Funeral director: Wm. H. Downey
Address: 291 Frederick Street
19. Aug. 18, 1945 Chas H Wurst
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/15 1945 at 2:30 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 1945 to 8/15 1945
and that I last saw h... alive on 8/10 1945

Immediate cause of death	DURATION
Pulmonary TB (Miliary)	5 M.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Victor D. McRon M. D. or other
Address: Hagerstown Md. Date signed 8/17 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU F.B.

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

★ Reg. Dist. No. (0835) 300

1. PLACE OF DEATH:
County Washington
City or town Sharpsburg Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 yrs
Hospital, institution, or street address where death occurred:
Sharpsburg Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Sharpsburg Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Sharpsburg Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ella May Mose

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Jerome Mose
6.(c) If alive, give age 74 years
7. Birth date of deceased (mo., day, yr.) Aug. 10 1875

8. AGE: Years	Months	Days	If less than one day
70		17	....hrs. ....min.

9. Birthplace Sharpsburg Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business House wife
FATHER 12. Name Jacob Renner
13. Birthplace Sharpsburg Md.
MOTHER 14. Maiden name Georgia Bowers
15. Birthplace Sharpsburg Md.
16. Informant Clifford Mose (son)
Address Sharpsburg Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 30 1945 (month) (day) (year)
Cemetery or crematory Mountain View Cemetery
Location Sharpsburg Md.
18. Funeral director Edith V Leaf
Address #7 Church St. Williamsport, Md.
19. 8-28 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1945 at 6:15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 to 8/27/45
and that I last saw h alive on Aug. 26 1945

Immediate cause of death	DURATION
Gastric Hemorrhage	12 hours.
Due to Carcinoma of Stomach	1 year.
Due to	
Other conditions Chronic Cholecystitis — probably Carcinoma of Liver.	10 yrs, 8 months.

(Includes pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Walter H. Sherly M.D.
M. D. or other
Address Sharpsburg, Md. Date signed 8/27/45

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SEP 6 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

08356

Reg. Dist. No. 307

1. PLACE OF DEATH:

County: Washington

City or town: Rohersville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

Mains St.

How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Rohersville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Mains St.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Minnie Mullendore

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Oliver D. Mullendore

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March. 15. 1872

8. AGE: Years: 73 | Months: 5 | Days: 8 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Locust Grove Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER

12. Name: Daniel H. Smith

13. Birthplace: Sharpsburg Wash. Co. Md.

MOTHER

14. Maiden name: Matilda Seltmacher

15. Birthplace: Rohersville Wash. Co. Md.

16. Informant: Oliver D. Mullendore

Address: Rohersville Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof: August. 25. 1945 (month) (day) (year)

Cemetery or crematory: Lutherans Cemetary

Location: Rohersville — Md.

18. Funeral director: Wm. J. Bast & Sons

Address: Boonsboro Md.

19. Aug. 24 1945 (Date rec'd by registrar) Mae Katherine Degenhart Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 23" 1945, at 5 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 22" 1945, to Aug. 23" 1945 and that I last saw [illegible] alive on Aug. 22" 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	20 hours
Due to: Arterial Hypertension	25 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Herbert Wade M.D. M. D. or other

Address: Boonsboro, Md. Date signed 8/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

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AUG 28 1945
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (80)

CERTIFICATE OF DEATH

08357 Reg. Dist. No. 301

1. PLACE OF DEATH:
County Washington County
City or town Williamsport Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 64 yrs
Hospital, institution, or street address where death occurred:
#111 S. Artizan St. Williamsport
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 111 S. Artizan St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Daniel Grant Mummert

3.(b) Social Security Number: 218-09-2196

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Grace Mummert
6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.): Aug. 24 1870

8. AGE: Years	Months	Days	If less than one day
74	11	17	hrs. min.

9. Birthplace: Indian Springs Md. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Miller Brothers Lumber C.
FATHER 12. Name: Samuel Mummert
13. Birthplace: Maryland
MOTHER 14. Maiden name: Elizabeth Ann Beard
15. Birthplace: Maryland
16. Informant: Grace Mummert
Address 111 S. Artizan St. Williamsport
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 13 1945 (month) (day) (year)
Cemetery or crematory Greenlawn Cemetery
Location Williamsport, Md.
18. Funeral director: Edith V Leaf
Address #7 Church St. Williamsport, Md.
19. Aug 12 1945 (Date rec'd by registrar) Mrs E Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/10/45 1945 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/10/45 1945 to 8/10/45 1945
and that I last saw him alive on 8/10/45 1945

	DURATION
Immediate cause of death: Cerebral Thrombosis	9 Days.
Due to: Hypertension	2 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C. F. Garver M. D. or Other
Address Williamsport Md. Date signed 8/10/45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 14 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

08358

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred: 414 East Franklyn

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 414 East Franklyn

(If rural, give LOCATION)

2.(a) If veteran, name war: World War No. 1

3.(a) FULL NAME: Beauford A. Munson

3.(b) Social Security Number: 214-09-1603

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Rhoda Munson

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 3rd, 1894

8. AGE: Years	Months	Days	If less than one day
51	2	12	..... hrs. ..... min.

9. Birthplace: Washington County (Town, county, and state)

10. Usual occupation: Mechanist

11. Industry or business: Pangborn Corp

FATHER — 12. Name: Frederick Munson

13. Birthplace: Washington County

MOTHER — 14. Maiden name: Amelia Shaffer

15. Birthplace: Washington County, Md.

16. Informant: Mrs. Beauford Munson

Address: Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 17, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown.

18. Funeral director: Fred W. Kraiss.

Address: Hagerstown

19. Aug 17 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15 19 45 at 9:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to Aug. 15 19 45

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Thrombosis ?	
Due to	
Due to (Patient was dead on arrival)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. Campbell M. D. or other

Address: Hagerstown, Md. Date signed: Aug. 15, 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 20 1945
BUREAU OF

La U Ann

66

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (79-1)

08359

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Washington
City or town: Keedysville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Last Mass
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ella Hoffman Newcomer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Aaron Newcomer
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 1 1867

8. AGE: Years: 78 | Months: 3 | Days: 10 | If less than one day: hrs. min.

9. Birthplace: Williamsport Md.
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER
12. Name: Mathias Hoffman
13. Birthplace: Washington Co. Md.

MOTHER
14. Maiden name: Nancy Hoffman
15. Birthplace: Washington Co. Md

16. Informant: Daniel Hoffman
Address: Smithsburg Md Rt 1

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 8/14/45 (month) (day) (year)
Cemetery or crematory: Dawn Hill Cemetery
Location: Waynesboro, Pa

18. Funeral director: Walter E. Grace
Address: 27 S. Church St. Waynesboro Pa

19. Aug. 14 19 45
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 11, 45 19 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2 19 45, to August 11 19 45
and that I last saw h alive on August 10 19 45

Immediate cause of death: Chronic Myocarditis — DURATION: 5 yr.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. W. Gellay M. D.
M. D. or other
Address: Boonsboro, Md Date signed: 8/13/45

M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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RECEIVED
AUG 17 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93rd)

CERTIFICATE OF DEATH

Reg. Dist. No. 4836 30 2

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 627 North Mulberry Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Emma L. Reese

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Lewis Reese

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 16, 1870

8. AGE:

Years	Months	Days	If less than one day
75	4	3	..... hrs. ..... min.

9. Birthplace: Mt. Lena, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business

FATHER
12. Name: Joseph Reese
13. Birthplace: Mt. Lena, Maryland

MOTHER
14. Maiden name: Mary E Gray
15. Birthplace: Mt. Lena, Maryland

16. Informant: Harry Reese
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8-21-45 (month) (day) (year)

Cemetery or crematory: Mt. Lena U.B. Cemetery

Location: Mt. Lena, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. Aug 21 1945 (Date rec'd by registrar) Stuart Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19 1945, at 7 30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22. 1943 to August 19 1945

and that I last saw h[er] alive on August 18. 1945

Immediate cause of death	DURATION
Arteriosclerotic heart disease	7
Due to	
Due to	
Other conditions Vascular hypertension	7

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R B Norment M.D.
M. D. or other

Address: Hagerstown Md. Date signed: 8/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 23 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington County
City or town: 141 S. Loust St. Hagerstown Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, institution, or street address where death occurred:
141 S. Loust St. Hagerstown Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 141 S. Loust St. Hagerstown
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mr. Martin Edward Rohrer

3. (b) Social Security Number: 219-05-2400

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Blanche Barber Rohrer
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Dec. 26 1871

8. AGE: Years	Months	Days	If less than one day
73	7	13	....hrs. ....min.

9. Birthplace: Williamsport, Md. (Town, county, and state)
10. Usual occupation: Shoe Legging Co. Hagerstown
11. Industry or business: Shoe Legging C. Hagerstown

FATHER
12. Name: Martin Rohrer
13. Birthplace: Va.

MOTHER
14. Maiden name: Alice McCardel
15. Birthplace: Md.

16. Informant: Blanche Rohrer
Address: 141 S. Loust St. Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 12 1945 (month) (day) (year)
Cemetery or crematory: Riverview Cemetery
Location: Williamsport, Md.

18. Funeral director: Edith V Leaf
Address: #7 Church St. Williamsport, Md.

19. Aug. 11 1945 (Date rec'd by registrar) Chas. H. Howard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug/10/945 19.... at 5A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....
and that I last saw h.... alive on ....19....

Immediate cause of death	DURATION
Chronic myocarditis. Cor.@.	
Duration, not stated.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no
Date of op.:
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: no Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. Richard Wells M. D. or DEPUTY MEDICAL EXAMINER WASH. CO., MD.
Address: Hagerstown, Md. Date signed: Aug. 10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 14 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

08362

Reg. Dist. No. 302

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: Washington County Hospital

How long in hospital or institution? 5 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No. 1111 Hamilton Blvd. (If rural, give LOCATION)

2.(a) If veteran, name war: /

3.(a) FULL NAME: Lucie Mae Roth

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Stewart Roth

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): January 31, 1894

8. AGE: Years	Months	Days	If less than one day
51	6	20	..... hrs. ..... min.

9. Birthplace: Hagerstown, Wash. Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: William Newcomer

13. Birthplace: Hagerstown, Maryland

MOTHER — 14. Maiden name: Laura B. Dennis

15. Birthplace: Hagerstown, Maryland

16. Informant: Stewart Roth

Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-22-45 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. Aug 21 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/30 1937, to 8/20 1945

and that I last saw h.. alive on August 20 1945

Immediate cause of death	DURATION
Subarachnoid Hemorrhage	35 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John N. Horncastle M. D. M. D. or other

Address: 154 W. Washington St. Hagerstown, Md. Date signed 8/20/45

RECEIVED
AUG 23 1945
BUREAU V.S.

Evidence for change of age is shown on

FILM No. G 98 SEP 19 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-2)

CERTIFICATE OF DEATH

Dr. Ditto
Dr. porterfield

18363

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown R # 2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Years
Hospital, institution, or street address where death occurred:
Cedar Lawn
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown R # 2
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Cedar Lawn
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Mrs. Myrtle Sands Schindel

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Benj. Randolph

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): October 23 1902

8. AGE: Years	Months	Days	If less than one day
~~43~~ 42	10	5	....hrs. ....min.

9. Birthplace: Hagerstown Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: William B. Sands
13. Birthplace: Hagerstown Md.

MOTHER
14. Maiden name: Lottie Smith
15. Birthplace: Hagerstown Md.

16. Informant: Benj. Randolph Schindel
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/30/45 (month) (day) (year)
Cemetery or crematory: Rest Haven cemetery
Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. Aug 29 1945 (Date rec'd by registrar) Chas. H. Bovard Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: August 28 1945 19.... at 11.30 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 26 '45 to Aug 28 1945 and that I last saw h... alive on Aug 26-45 19....

Immediate cause of death	DURATION
Gunshot wound of head	Aug 28 '45
Due to (Self inflicted)	Yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of Aug 28 '45
Where did injury occur? (Home) Hagerstown (County) Md. (State)
(City or town)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Injured at work?

23. SIGNATURE: D W Ditto M.D. or other
Address: Hagerstown Md. Date signed: 8/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 31 1945
BUREAU V. S.

60

Dr. Nicely

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

★ Reg. Dist. No. 0836 17

1. PLACE OF DEATH:
County: Washington County
City or town: Hagerstown Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 yrs
Hospital, institution, or street address where death occurred:
421 W. Franklin St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 421 W Franklin St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George G Smith

3.(b) Social Security Number: 217-09-9898A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife: Nannie Jessup Smith
Deceased
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 25 1870

8. AGE: Years	Months	Days	If less than one day
74	8	15	hrs. min.

9. Birthplace: Williamsport, Md.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Shoe & Legging Co. Hagerstown

FATHER
12. Name: Fredrick Smith
13. Birthplace: Germany

MOTHER
14. Maiden name: Mary Elizabeth Spangler
15. Birthplace: Williamsport, Md.

16. Informant: George Smith
Address: 421 W. Franklin St. Hagerstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 12 1945 (month) (day) (year)
Cemetery or crematory: Riverview Cemetery
Location: Williamsport, Md.

18. Funeral director: Edith V Leaf
Address: #7 Church St. Williamsport, Md.

19. August 11 19 45 (Date rec'd by registrar) C Kent Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9 1945 19 ..., et ... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 30, 1945 19 ... to August 9 19 45
and that I last saw him alive on July 27, 1945 19 ...

Immediate cause of death	DURATION
Carcinoma of the urinary bladder	Indef.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: B B Blickenderfer M.D. M. D. or other
Address: 148 W. Washington St. Date signed: 8/11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 14 1945
BUREAU V.S.

Dr. Ralph Young 58

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 08365 Reg. No. 362

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Years
Hospital, institution, or street address where death occurred:
124 South Locust St.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 124 South Locust St.
(If rural, give LOCATION)
2.(a) If veteran, name war none

3.(a) FULL NAME Mrs. Nell Hazel Smith

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Earl L.
6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) February 1 1892

8. AGE: Years	Months	Days	If less than one day
53	6	6	...hrs. ...min.

9. Birthplace Eakles Mill Wash. Co. Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Martin L. Gouff
13. Birthplace Locust Grove Md.

MOTHER
14. Maiden name Fannie Stine
15. Birthplace Locust Grove Md.

16. Informant Earl L. Smith
Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/9/45 (month) (day) (year)
Cemetery or crematory Rest Haven Cemetery
Location Hagerstown Md.

18. Funeral director Andrew K. Coffman
Address Hagerstown Md.

19. Aug. 9, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1945 at 6.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/1/45 to 8/7/45 and that I last saw her alive on 8/3/45

Immediate cause of death	DURATION
Cerebral Apoplexy	1 Day
Due to Pulmonary Edema	1 yr.
Due to Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. F. Young M. D. or other
Address 21 Diamond Ave Hagerstown Md. Date signed 8/9/45

RECEIVED
AUG 13 1945
BUR

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (28)

08366

82

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Washington

City or town: Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Smithsburg #2

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Franklin E. Spencer

3.(b) Social Security Number: 173-03-7514

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Ida Schildt

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): July 1, 1879

8. AGE: Years	Months	Days	If less than one day
66	1	23	...hrs. ...min.

9. Birthplace: Smithsburg #2 Md.
(Town, county, and state)

10. Usual occupation: Foundry Labor

11. Industry or business: Funk Co. Waynesboro, Pa.

FATHER
12. Name: Miram Spencer
13. Birthplace: Washington Co. Md

MOTHER
14. Maiden name: Melinda Eyler
15. Birthplace: Frederick Co. Md.

16. Informant: Mrs. Ida Schildt Spencer
Address: Smithsburg #2 Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof 8/27/45 (month) (day) (year)

Cemetery or crematory: Washington Cemetery

Location: Smithsburg #2 Md

18. Funeral director: Walter F. Bunt

Address: 17 Church St. Waynesboro, Pa

19. Aug 25 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug - 24 1945 at 7 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug - 20 1945 to Aug - 24 1945

and that I last saw him alive on Aug - 23 1945

Immediate cause of death	DURATION
(a) Acute Pancreatitis	5 days
Due to: (b) Chr. Cholecystitis	3
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wallis H. Weiland M.D.
M. D. or other

Address: 152 Main Waynesboro Pa Date signed: 8/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

ED
AUG 28 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9-2)

CERTIFICATE OF DEATH

08367

★ Reg. Dist. No. 302

51

1. PLACE OF DEATH:
County Washington
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Ohio County Franklin
City or town Westerville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 163 West Homes Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Katherine Elizabeth Spessard

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

B.(b) Name of husband or wife: Arthur R. Spessard
B.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): June 21, 1884

8. AGE:	Years	Months	Days	If less than one day
	61	1	12	...hrs. ...min.

9. Birthplace: Chewsville, Wash. Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Lewis B. Rhinehart
13. Birthplace: Chewsville, Maryland

MOTHER
14. Maiden name: Virginia Brown
15. Birthplace: Chewsville, Maryland

16. Informant: Arthur R. Spessard
Address: Westerville, Ohio

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-5-45 (month) (day) (year)
Cemetery or crematory: Smithsburg Cemetery
Location: Smithsburg, Maryland

18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Maryland

19. Aug 5, 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 3, 1945, at 7.25 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 20, 1945, to Aug 3, 1945, and that I last saw h... alive on Aug 3, 1945

Immediate cause of death	DURATION
Acute Dilatation of Heart	3 days
Due to Myocarditis Gallbladder Hypertension & Enteritis	2 years
Due to Gallstones	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: J. G Kohler M. D.
Address: Smithsburg Date signed 8/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 7 1945
BUREAU V.S.

08368

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, Institution, or street address where death occurred:
724 Potomac Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 724 Potomac Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3. (a) FULL NAME: Ruth M. Spidell

3. (b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Emerson Spidell
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 8, 1876

8. AGE: Years	Months	Days	If less than one day
69	5	10	hrs. min.

9. Birthplace: Strawsburg, Franklin, Penna. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: own home

FATHER
12. Name: Jacob Spidell
13. Birthplace: St. Thomas, Pennsylvania

MOTHER
14. Maiden name: Mary Pew
15. Birthplace: Pennsylvania

16. Informant: Mrs. L. F. Harrison
Address: Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 22, 1945 (month) (day) (year)
Cemetery or crematory: Rest Haven Cemetery
Location: Hagerstown, Md.

18. Funeral director: Scott F. Minnich & Son
Address: Hagerstown, Md.

19. Aug 20 1945 (Date rec'd by registrar) Chas H. Powers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18, 1945, at 11:45pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1945, to Aug 18 1945
and that I last saw alive on Aug 4 - 45 1945

Immediate cause of death	DURATION
Ca. Myocarditis	6 yr
Due to	
Due to Diabetes Carcinoma (fatal)	5 yr 6 mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Hagerstown Md. Date signed: 8/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 22 1945
BUREAU V. S.

Dr. Kneisley 52

08369

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington (WITHIN LIMITS)
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25Years
Hospital, institution, or street address where death occurred:
745 Spruce St.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland (OUTSIDE LIMITS) County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 745 Spruce St.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Elam Monroe Stouffer

3.(b) Social Security Number 214-09-1441

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Alice

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) June 2 1890

8. AGE: Years	Months	Days	If less than one day
55	2	3	....hrs. ....min.

9. Birthplace Chambersburg Franklin Co. Pa.
(Town, county, and state)

10. Usual occupation Stock Clerk

11. Industry or business Victor products Corp

FATHER
12. Name Daniel Stouffer
13. Birthplace Chambersburg Pa.

MOTHER
14. Maiden name Susan Mongan
15. Birthplace Ringgold Md.

16. Informant Mrs. Alice Stouffer
Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/8/45 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown Md.

18. Funeral director Andrew K. Coffman
Address Hagerstown Md.

19. August 8 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1945 19.... at 10. P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5, 1945 19.... to August 5 19 45
and that I last saw him alive on August 5, 1945. 19....

	DURATION
Immediate cause of death Coronary occlusion	2½ hours
Due to Coronary sclerosis	Indefinite
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B. B. Sheisley M.D.
M. D. or other
Address 148 W. Washington St., Date signed 8/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 10 1945
BUREAU V.R.

65

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

Dr. Campbell

08370

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Days
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 10 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 227 Frederick St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Emma Catherine Stouffer

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William
6.(c) If alive, give age: 83 years

7. Birth date of deceased (mo., day, yr.): July 9 1866

8. AGE: Years	Months	Days	If less than one day
79	1	2	...hrs. ...min.

9. Birthplace: Clearspring Wash. Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: Henry Hull
13. Birthplace: Clearspring Md.

MOTHER
14. Maiden name: Marie Dennis
15. Birthplace: Clearspring Md.

16. Informant: Clarence Stouffer
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/13/45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. Aug. 11 1945 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: August 11 1945 at 5 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 1945, to Aug. 11 1945, and that I last saw h... alive on Aug. 10 1945.

	DURATION
Immediate cause of death: Acute Cardiac Failure	10 days
Due to: Cardio-Vascular Renal Disease	1 Yr.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ...Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: H. S. Campbell M. D. or other
Address: Hagerstown Md. Date signed: 8/11/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 14 1945
BUREAU V.S.

52

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

08371

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 61 years

Hospital, institution, or street address where death occurred: 810 Oak Hill Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 810 Oak Hill Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: Hattie May Strole

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles F. Strole

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): October 31, 1883

8. AGE: Years	Months	Days	If less than one day
61	9	3	....hrs. ....min.

9. Birthplace: Hagerstown, Wash., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER — 12. Name: Alvin M. Ordway

FATHER — 13. Birthplace: Vermont

MOTHER — 14. Maiden name: Emma O. Secrist

MOTHER — 15. Birthplace: Hagerstown, Md.

16. Informant: Charles F. Strole

Address: Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 6, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Md.

18. Funeral director: Scott F. Minnich & Son

Address: Hagerstown, Md.

19. Aug. 5, 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4, 1945 at 10:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18, 1945, to Aug. 4, 1945

and that I last saw h... alive on Aug. 1, 1945

Immediate cause of death	DURATION
Acute Congestive Heart failure	July 18, 1945 Aug 4, 1945
Due to Acute Dilatation of Heart.	7 hours.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. No

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: X Date of: X

Where did injury occur? (City or town) X (County) X (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. Howard Yeager M. D. or other

Address: Hagerstown Md. Date signed: Aug. 4, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 7 1945
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BPa)

CERTIFICATE OF DEATH

118372

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 years

Hospital, institution, or street address where death occurred:

131 N. Potomac St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 131 N. Potomac St.

(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: Ada Elizabeth Tanquary

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Charles W. Tanquary

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 17, 1860

8. AGE:

Years	Months	Days	If less than one day
85	5	4	..... hrs. ..... min.

9. Birthplace: Culpepper, Culpepper Co., Va.
(Town, county, and state)

10. Usual occupation: -

11. Industry or business: -

FATHER
12. Name: Theopholus Tanquary
13. Birthplace: Virginia

MOTHER
14. Maiden name: Lucy Kelby
15. Birthplace: Virginia

16. Informant: Mrs Harry C. Marsh
Address: Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 24, 1945 (month) (day) (year)

Cemetery or crematory: Centenary Reformed Cemetery

Location: Winchester, Va.

18. Funeral director: Scott F. Minnich & Son

Address: Hagerstown, Md.

19. Aug 24 19 45 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 21, 1945, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 9, 1943, to Aug. 21, 1945 and that I last saw h... alive on August 21, 1945

Immediate cause of death: Cirrhosis cardiovascular renal disease. — DURATION: 2 years

Due to: .....

Due to: .....

Other conditions: None

(Include pregnancy within 3 months of death)

Major findings of operations: No operations — Date of op. .....

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: La Bree M. D. ~~or other~~

Address: Hagerstown Md. Date signed 8/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 27 1945
BUREAU V. S.

81

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

08373

CERTIFICATE OF DEATH

★ Reg. Diat. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Funkstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mo
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Wash
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1000 - S. Car. Ave. S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John D. Torrey Sr.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife: Anita S. Torrey
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 7/23/1859

8. AGE: Years	Months	Days	If less than one day
86			hrs. min.

9. Birthplace: Mass
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER 12. Name	Henry Albert
FATHER 13. Birthplace	Mass.
MOTHER 14. Maiden name	Abby F. B. Parker
MOTHER 15. Birthplace	Mass

16. Informant: Cremation, John D. Torrey Jr.
Address: 1000 - S Car. Ave. S.E.
17. Cremation (Burial, cremation, or removal. Which?) Date thereof 8/25/45 (month) (day) (year)
Cemetery or crematory: Wm. Gies Crematory
Location: Wash. D.C.
18. Funeral director: J. Wm. Gies Sons Co.
Address: 900 G St. N.E. - DC
19. Aug 25 1945 (Date rec'd by registrar) Elsie H Howard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 25 1945, at 11:40 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 1945 to Aug 25 1945
and that I last saw h.e alive on Aug 25 1945

Immediate cause of death	DURATION
Arterio-Sclerotic Heart Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Sidney Rovenstein M.D.
M. D. or other
Address: Funkstown Md. Date signed 8/25/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dly, [illegible]

RECEIVED
AUG 28 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53-C ✓

08374

CERTIFICATE OF DEATH ★ Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
230 East Franklin Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 230 East Franklin Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Clyde F. Warner

3.(b) Social Security Number: 214-09-3293

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Naomi V. Warner
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): May 10, 1886

8. AGE: Years	Months	Days	If less than one day
59	3	0	....hrs. ....min.

9. Birthplace: Hagerstown, Wash. Co. Md.
(Town, county, and state)
10. Usual occupation: Retired grocerman
11. Industry or business

FATHER
12. Name: Richard Warner
13. Birthplace: Hagerstown, Maryland

MOTHER
14. Maiden name: Clarine V. Bloom
15. Birthplace: Hagerstown, Maryland

18. Informant: Mrs. Clyde F. Warner
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-12-45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Maryland
18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Maryland

19. Aug. 11 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 10 1945, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 17 1945, to Aug 10 1945
and that I last saw h... alive on Aug 9 1945

Immediate cause of death	DURATION
Carcinoma of thyroid	5
Metastasis Cerebral	1
Due to Organic Heart Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. H. Porterfield M.D. M. D. or other
Address: 13 East Washington Date signed 8/11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 14 1945
BUREAU U.S.

Dr. Pyatt 67

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08375

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? IO Hours
Hospital, institution, or street address where death occurred:
Wash. Co. Hosp.
How long in hospital or institution? 10 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 673 Forest St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Alice Jane Watson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George W.
6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): January 2 1908

8. AGE: Years	Months	Days	If less than one day
37	7	10	....hrs. ....min.

9. Birthplace: Hagerstown Wash. Co. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: Denton Cline
13. Birthplace: Hagerstown Md.

MOTHER
14. Maiden name: Annie Jacobs
15. Birthplace: Hagerstown Md.

16. Informant: George W. Watson
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/14/45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. Aug. 14. 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 12 1945 19.... at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 13 1945 to Aug 12 1945 and that I last saw her alive on Aug 13 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	6 hours
Due to: Unknown	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Wm. H. Prather M. D.
Address: Hagerstown, Md. Date signed 8.13.45

(M) MARGIN RESERVED FOR BINDING (1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 744 (1)

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AUG 17 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

08376

Reg. Dist. No. 303

6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Big Pool
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Big Pool
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Edward Wiley

3.(b) Social Security Number: 705-10-5779

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Ica Wiley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 17 1871

8. AGE: Years	Months	Days	If less than one day
74	5	17	..... hrs. ..... min.

9. Birthplace: Washington County
(Town, county, and state)

10. Usual occupation: Bridge Forman

11. Industry or business: W.M.R.R.Co.

FATHER
12. Name: Not Known
13. Birthplace: Not Known

MOTHER
14. Maiden name: NOt Known
15. Birthplace: ;; ;;

16. Informant: Albert L. Wiley

Address: Big Pool, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 7 1945 (month) (day) (year)

Cemetery or crematory: Evangelical Cemetery

Location: Shanktown, Md.

18. Funeral director: Snyder-Rowland

Address: Clearspring, Md.

19. Aug 7, 1945 (Date rec'd by registrar) Joseph W. Murray per S.B. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 3 19 45, at 4:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15 19 42, to July 3, 19 45 and that I last saw h.m.m. alive on Aug 3, 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to: Arterio Sclerosis	6 yrs.
Due to:	
Other conditions: Cerebral Hemorrhage	1 year

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: David P. Brewer M.D.
M. D. or other

Address: Clear Spring Md. Date signed 8/6/45

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AUG 9 1945
BUREAU V. S.

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

0837 802

FILM No. G 98 SEP 18 1945

Reg. Diat. No. 305

1. PLACE OF DEATH:

County: Washington

City or town: San Mar - Johnny Memorial Home
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Months / Life

Hospital, institution, or street address where death occurred: 7 Months

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Reid, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Reid, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Lupah N. Willingham

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Charles I.

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 25, 1871.

8. AGE: Years	Months	Days	If less than one day
-74- 73	9	5	..... hrs. ..... min.

9. Birthplace: Hagerstown
(Town, county, and state)

10. Usual occupation: Home work

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Supt of San Mar Home

Address: San Mar, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 3, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Hagerstown

18. Funeral director: Fred W. Kraiss.

Address: Hagerstown

19. Sept. 2, 1945 (Date rec'd by registrar) John H. Bard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 30 1945 at 10.10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1945 to Aug 30 1945

and that I last saw h... alive on August 30 1945

Immediate cause of death

	DURATION
Carcinoma of duodenal	
Due to end of stomach	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: G. W. LeVan M.D.
M. D. or other

Address: Boonsboro, Date signed: 8/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 4 1945
BUREAU U.S.

87

08378

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 530 Washington Square
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Daisy Sowers Wilson, Sr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William H. Wilson, Sr.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 2, ~~1876~~ 1876

8. AGE: Years	Months	Days	If less than one day
68	10	26	..... hrs. ..... min.

9. Birthplace: Two Locks, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Samuel Sowers
13. Birthplace: Clearspring, Maryland

MOTHER
14. Maiden name: Sallie Kreps
15. Birthplace: Clearspring, Maryland

16. Informant: Harry Charles
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-30-45 (month) (day) (year)
Cemetery or crematory: St. Paul Cemetery
Location: Western Pike

18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Maryland

19. Aug 30 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/28 1945, at 8:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/1 1945, to 8/28 1945
and that I last saw h[illegible] alive on 8/27 1945

Immediate cause of death: Chronic Endocarditis

	DURATION
" nephritis	2-3
" Hepatitis.	years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: 0

Date of op.

Autopsy results: 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Victor D. Miller M. D. or other

Address: 131 W. WASHINGTON, ST. Date signed 8/28/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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SEP 1 1945
BUREAU V. S.